Communicable Disease UPDATE

Newsletter of the Bureau of Communicable Disease Control, Massachusetts Department of Public Health Vol. 11, No.3 Summer 2003

Sexually Transmitted Diseases and Adolescents

Recent reports by the National Campaign to Prevent Teen Pregnancy and the Kaiser Family Foundation suggest that teens continue to have significant gaps in their understanding of STDs and are engaging in sexual activity at a younger age. Early sexual activity is associated with increased risk for greater number of sexual partners, acquisition of STDs and pregnancy.

The National Campaign to Prevent Teen Pregnancy: *14 and Younger: The Sexual Behavior of Young Adolescents* [1] is a review of literature and data sets regarding sexual behavior in younger teens. The report concludes that, during the 1990s, up to 18-19% of teens aged 14 years or younger were sexually active. Boys were slightly more likely to have had sex than girls. Despite decreases in sexual activity among 15-19 year old girls, the proportion of girls 14 years old and younger having sexual intercourse increased over the same time period. However, sexual activity among younger teens is more likely to be sporadic, rather than consistent.

Early sexual activity is linked to a greater number of sexual partners over time and increased risks for both pregnancy and STDs. Younger teens are more likely to have relationships with older partners, and the older the partner the more likely that sexual intercourse is a part of the relationship. Approximately one in seven sexually experienced 14-year-old girls report having been pregnant. Only about one-third of parents of sexually experienced 14-year-olds are aware of their child's sexual activity.

The Kaiser Family Foundation's *National Survey of Adolescents and Young Adults: Sexual Health Knowledge, Attitudes and Experiences*[2] found that one in five adolescents thought that birth control pills protected against HIV infection and other STDs. Many adolescents were unaware that STDs could be transmitted by oral sex. In general, accurate knowledge of STDs and how they are transmitted was lacking among adolescents. The survey found a very strong desire on the part of adolescents and young adults for more information about sex and sexual health. One quarter reported a need for more information about condoms, 40% wanted to acquire more capacity to communicate effectively with partners and three-quarters expressed a need for more information about how to recognize STDs and HIV infection, what testing and screening involves, and where they can get tested for STDs and HIV infection.

In Massachusetts, rates of reported chlamydia infection and gonorrhea reached historic low levels in the mid-1990s. However, since that time, rates of reported infection have increased in teens of all ages. This trend has been gradual in adolescents 15-19

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Improving Hepatitis C Surveillance

Hepatitis C virus (HCV) infection is reportable to local boards of health and the Massachusetts Department of Public Health (MDPH). It is the responsibility of local health departments (LHD) to investigate cases of HCV infection. Unfortunately, with an extremely high volume of cases being reported, many health departments do not have the resources to manage the caseload. This has resulted in limited data collection and delays in processing and analyzing surveillance information.

With input from the statewide Hepatitis C Advisory Committee—whose members include public health nurses, consumers, health care and social service providers, and MDPH staff — the HCV surveillance system has been revised. MDPH will be working directly with medical providers and institutions to obtain information on all cases of non-acute HCV infection. In most cases, the only data requested will be demographic and laboratory testing information. Only a small (randomly-selected) sample of cases will be assessed for risk history. All relevant information obtained with this system will be provided to the appropriate LHD in a line listing to be sent out weekly.

For acute cases of HCV infection, except in the case of LHDs with the capacity to lead investigations, MDPH epidemiologists will follow up most cases. In either situation, LHDs will be an educational resource for HCV patients choosing to contact them.

This system should allow HCV surveillance data to be collected more efficiently so that the data can be better used for program planning. It will also significantly reduce the reporting burden of LHDs. The implementation date is anticipated for late summer, 2003, (more information on details of the system's operation will be available). If you have questions about the proposed changes to Hepatitis C surveillance, please call the Division of Epidemiology and Immunization at 617-983-6800.

IMPORTANT NEWS

Please see page 8 for important information on future issues of Communicable Disease Update

Inside

TB

QuantiFERON Update

The tuberculin skin test (TST) has long been the standard method used to diagnose tuberculosis infection. In 2001, a new test, QuantiFERON®-TB (QFT) was approved by the Food and Drug Administration (FDA) as an "aid for detecting latent *Mycobacterium tuberculosis* infection (*1*)." However the TB Division has determined that the test needs further evaluation before it can be provided in our TB Clinics.

QuantiFERON®-TB utilizes whole blood and measures the release of interferon-gamma by blood leukocytes in response to stimulation by purified protein derivative. The QuantiFERON®-TB test does not measure the same components of the immunologic response as does the TST, but results are moderately concordant.

The test can be accomplished after a single patient visit. The test does not boost immune responses, although prior TST may affect the QFT response. Compared with TST, QFT results are less subject to reader bias and error, since the output is a numerical stimulation index. As with the TST, interpretation and indicated applications of QFT differ for persons according to their risk for tuberculosis infection and for developing TB.

CDC recently published Guidelines for the use of QFT. As with the TST, testing should be conducted among groups at risk for recent infection with *M. tuberculosis* and those who, regardless of duration of infection, are at increased risk for progression to active TB. Keeping this in mind, CDC recommends QFT can be considered for latent TB infection (LTBI) screening as follows:

- initial and serial testing of persons with an increased risk for LTBI
- initial and serial testing of persons who are, by history, at low risk for LTBI but whose future activity might place them at increased risk for exposure
- testing of persons for whom LTBI screening is performed but who are not considered to have an increased probability of infection (e.g., entrance requirements for certain schools and workplaces).

Confirmation of QFT results with TST is possible because performance of QFT does not affect subsequent QFT or TST results. The probability of LTBI is greatest when both the QFT and TST are positive. Considerations for confirmation are as follows:

- When the probability of LTBI is low, confirmation of a positive QFT result with TST is recommended before initiation of LTBI treatment.
- TST can also be used to confirm a positive QFT for persons at increased risk for LTBI. However, the need for LTBI treatment when QFT is positive and the subsequent TST is negative should be based on clinical judgment and perceived risk.
- Negative QFT results do not require confirmation, but results can be confirmed with either a repeat QFT or TST if the accuracy of the initial test is in question.

QFT is not recommended for:

- Evaluation of persons with suspected tuberculosis, since active TB can actually suppress the QFT, so the TST should be used if active TB is suspected.
- Assessment of contacts of persons with infectious tuberculosis, because rates of conversion of QFT and TST after a known exposure to *M. tuberculosis* have not been compared.
- Screening of children aged <17 years, pregnant women, or for persons with clinical conditions that increase the risk for progression of LTBI to active TB (*e.g.,* human immunodeficiency virus infection).
- Confirmation of TST results because injection of PPD for TST might affect subsequent QFT results.
- Diagnosis of *M. avium* complex disease.

PUBLIC HEALTH NURSE SPOTLIGHT

This issue of Communicable Disease Update highlights Public Health Nurse Linda Saravo, RN, of the Fall River Health Department. Now in her 17th year with the department, Linda is frequently referred to as "the contagious nurse" or "the communicable nurse" by her patients in the community. In addition to being responsible for disease investigation, she functions as the Fall River Chest Clinic nurse, performs DOT (directly observed therapy) and monitors TB patients in the community. Additionally she performs tuberculin skin testing, and assists with immunizations, both at City Hall and "on site".

Linda's favorite part of the job is the investigative process. As a child she remembers being fascinated by an old Ben Casey episode that investigated a hepatitis B outbreak in a college lab setting. It was to be the inspiration for her career in disease prevention and control. Linda leaves "no stone unturned" when conducting contact investigations. She credits her early job experience, working with physically and medically challenged individuals, in honing the nursing skills necessary to work with patients unwilling or unable to communicate their symptoms. In a culturally diverse setting, these skills are critical to her work.

The elderly and those who fall outside the mainstream of society find a special place in Linda's heart. Linda recounts a situation

where she befriended an older patient who was hospitalized and who asked Linda if he could use her name as "next of kin". She was the only person at his burial, but felt honored that she was able to be the family he did not have.

In response to the question, what is the best way someone could compliment her on her work Linda replies: "Dr. Sheehan, the Fall River TB Physician, in speaking with a colleague, stated that Linda is the best nurse advocate, she stands up for the patients' rights and cares about the patients she sees".

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Pneumoccoal Conjugate Vaccine Shortage Over!

Pneumococcal conjugate vaccine (PCV7) production and supply are now sufficient to permit a return to the routine 4-dose schedule for all infants and young children. The Centers for Disease Control and Prevention (CDC) and the American Academy of Pediatrics (AAP) are recommending that all health-care providers identify those children for whom doses have been deferred and recall them to complete the series.

Background
On December 28, 2001, the Massachusetts Department of Public Health (MDPH) issued an advisory alerting providers that a "moderate" shortage of PCV7 existed in Massachusetts. Providers were asked to defer the 4th dose in healthy children < 24 months of age and any doses in healthy children between 24-59 months of age, but to continue immunization of all children with medical conditions placing them at high risk for invasive pneumococcal disease. They were also requested to maintain recall lists of children whose doses were deferred. The shortage never became severe enough to affect the infant schedule.

Prioritization of Groups for Catch-Up
Since providers may not be able to recall all children simultaneously due to logistical or vaccine supply issues, groups to be recalled should be prioritized in this order:

1. **Any infants < 12 months of age with < 3 doses or high-risk* children of any age with < 4 doses.** In Massachusetts, there should not be any under-immunized children in these categories due to the vaccine shortage. However, if they are identified in your practice, they should be prioritized first for recall.

   * High risk groups include: children with sickle cell disease, asplenia, human immunodeficiency virus infection, chronic illness (including cardiac disease, pulmonary disease, diabetes), CSF fluid leak, cochlear implant, or other immunocompromising conditions and treatments.

2. **Children < 24 months of age with < 4 doses.** Children < 24 months of age whose 4th dose was deferred should be recalled second.

3. **Children 24 – 59 months of age with < 4 doses.** Older children whose 4th dose was deferred should be recalled third. Prioritization within this older age group, if needed, would be given to children who are 24-35 months, American Indian/Alaska Native and black children, and those who attend group child care centers.

Vaccine Ordering
MDPH now advises providers to return to their normal vaccine ordering patterns for PCV7 by increasing their next monthly vaccine order by 30 % plus additional doses to catch-up under-immunized children. Vaccine orders will need to be increased by 30 to 50 % over the next few months until catch-up is complete. Providers are encouraged to order vaccine on a monthly basis and maintain no more than a 1-2 month inventory at any given time. If you have questions, contact the Vaccine Management Unit at 617-983-6828

Please report cases of invasive pneumococcal disease to both your local board of health and the MDPH Division of Epidemiology and Immunization at 617-983-6800 or 888-658-2850. If you have any questions, please call the MDPH Immunization Program at 617-983-6800 or 888-658-2850.

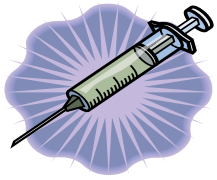
Important Information About Availability of Flu Vaccine

Due to funding reductions, the amount of influenza vaccine available through the Massachusetts Department of Public Health (MDPH) for this coming influenza season has been reduced. State-supplied influenza vaccine is being prioritized to high-risk children, long-term care facilities and public provider sites (i.e. local boards of health, visiting nurse associations and community health centers).

Unfortunately, MDPH will not be able to supply influenza vaccine for adults seen at private provider offices. However, flu vaccine is available for purchase from the following manufacturers.

Aventis	800-822-2463
General Injectable and Vaccine (Medeva)	800-521-7468

If you have questions, please contact the MDPH Vaccine Management Unit at 617-983-6828.



Protect Your Patients, your famiily and yourself!

All health care workers should get a flu vaccine every year!

Congratulations to Dr. Susan Lett, Medical Director of the Massachusetts Department of Public Health, Immunization Program, who was recently elected an Honorary Fellow of The American Academy of Pediatrics.

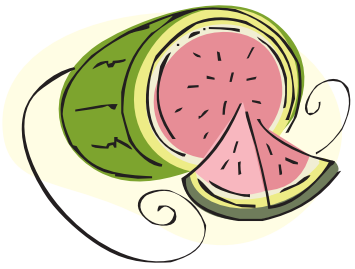
STD

Welcome Thomas Bertrand, new Director of the Division of STD Prevention

The Bureau of Communicable Disease Control and the staff of the Division of Sexually Transmitted Disease Prevention welcome Tom Bertrand as the new Division Director. Many at MDPH know Tom from his years of service with the health department in the neighboring state of Rhode Island. He comes to the Massachusetts Department of Public Health from the Rhode Island Department of Health, where he served for 10 years, most recently as Assistant Division Director for the Division of Disease Control and Prevention. Prior to holding that position, he served in several positions at the RIDOH, including Chief Administrator of the Office of Communicable Diseases, and manager of the Immunization Program and the Environmental Lead Program. Prior to working in Rhode Island, Tom was with the New York Department of Health.

Tom has served as the Chair of the Ocean State Adult Immunization Coalition and has been active in the National Coalition of STD Directors, serving on the Board and as Treasurer. He received his Masters in Public Health in Epidemiology from the State University of New York at Albany and also has an M.A. degree in Psychology from Columbia University.

Tom Bertrand comes to Massachusetts with broad experience in public health practice, program management, epidemiology and STD prevention and control. He has been involved in STD prevention and control on a state and national level for the past five years. We look forward to his continued leadership in this area in his new role with MDPH. Tom joined our staff on June 23, 2003. His office is located at the State Laboratory Institute, 305 South Street, in Jamaica Plain.



TB Nurse Spotlight

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The TB Division is pleased to recognize Linda Saravo for her dedication and commitment to TB Prevention and Control in the city of Fall River. The Fall River Health Department and the TB Clinic at St. Anne's Hospital are fortunate to have her as part of their team.

STDs and Adolescents

Continued from page one

years old (see Figure 1), but amounts to an overall 53% increase in chlamydia infection and 38% increase in gonorrhea. Some of this gradual increase in reported chlamydia infection, and to a lesser extent in gonorrhea, may be due to the adoption of new, easier and more sensitive diagnostic tests and increased screening of asymptomatic individuals. In individuals aged less than 15 years old, stable and even decreasing rates of infection through 2000 have been followed by dramatic increases in reported infections in 2001 and 2002 (between 2000 and 2002, 2.5-fold increase in chlamydia infection and 3.3-fold in gonorrhea, see Figure 2).

While numbers of cases in younger teens are small (<300 for chlamydia and <100 for gonorrhea), the numbers had been very stable over a number of years. This dramatic and worrisome increase in STDs among younger teens is consistent with other indications of increased sexual activity in this age group and the pattern of having older partners who may be more likely to have infection. Fortunately, preliminary data for the first half of 2003 suggest slowing of this trend, but we must await final results.

Recent reports and trends in reported STDs in Massachusetts point to the need for more sex and HIV/STD prevention education for teens, especially younger teens.

Figure 1: Rates of Reported Chlamydia Infection and Gonorrhea Among Persons 15 to 19 Years Old in Massachusetts, 1993-2002

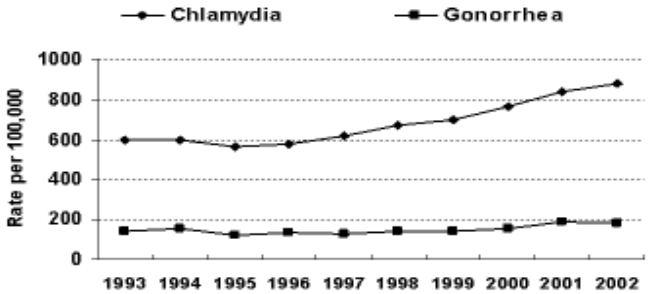
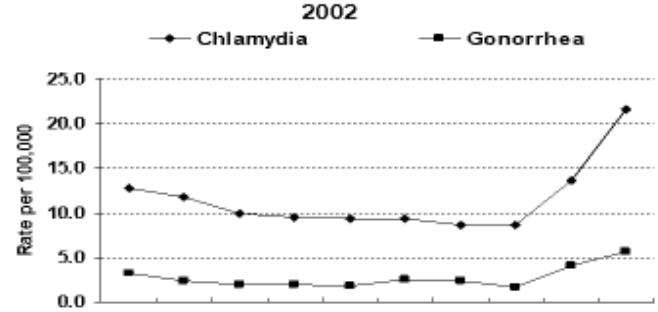


Figure 2: Rates of Reported Chlamydia Infection and Gonorrhea in Massachusetts Among Persons Under 15 Years of Age, 1993-2002



The Return of SARS

Although the identification of Severe Acute Respiratory Syndrome (SARS) cases has ended and travel advisories and alerts for affected areas have been removed, it is expected that SARS will re-emerge, most likely in areas already affected by the early 2003 outbreak.

You are the medical director at a college attended by students from all over the world. Many of your students come from mainland China (an area with high SARS activity during the 2003 outbreak). Because it appears that SARS has re-emerged in mainland China, you are concerned about a special program at your school which will be attended by students from around the world, including China. Should you refuse admission to the students from China, allow them to come but quarantine them, or do nothing?

SARS is a respiratory illness that was identified in countries throughout the world during early 2003. The incubation period for SARS is usually 2 to 7 days but may be as long as 10 days. Early symptoms include fever (>100.4°F [>38.0°C]), chills, headache, malaise, myalgia, and mild respiratory symptoms. After 3 to 7 days, a lower respiratory phase of illness begins with the onset of a dry, nonproductive cough. Ten to twenty percent of cases require intubation and mechanical ventilation.

It is thought that SARS is caused by a novel coronavirus (SARS Co-V) that is spread person-to-person through respiratory droplets and that a person is infectious when he/she is symptomatic (e.g., fever and respiratory symptoms). Close contact with a SARS case is necessary for transmission of the virus. Close contact includes living with a person, direct physical contact with a person, kissing, embracing, and sharing food or beverages. Areas affected by the 2003 outbreak include mainland China, Hong Kong, Taiwan, Vietnam, Singapore and Toronto, Canada. Persons coming to the US from areas with active SARS cases were instructed to monitor their health for 10 days after their departure from the high-risk area.

Students from China should not be refused admission to your school; however, you should set up a system for monitoring the high-risk student's health for the 10-day monitoring period and develop a plan of action should a student become symptomatic. The 10-day monitoring period should include the following:

1. Monitor high-risk students for fever and perform a daily assessment of respiratory symptoms.

2. In the absence of both fever and respiratory symptoms, students do not need to limit their activities during the 10-day monitoring period. However, the student's activities should be tracked so contact tracing may be implemented should the student become symptomatic.

3. If a high-risk student develops a fever OR respiratory symptoms during the 10-day monitoring period, she/he should be evaluated by a healthcare provider immediately. The healthcare provider should be notified that the patient may have been exposed to SARS so the necessary infection control precautions are implemented.

4. A high-risk symptomatic student should follow the infection control precautions listed below:

- If fever OR respiratory symptoms occur, the student should not participate in activities but should be isolated in a private room while awaiting a health-care evaluation.

- If symptoms improve or resolve within 72 hours after first symptom onset, the student may resume activities after consultation with local public health authorities.

- If the student meets or progresses to the SARS case definition (e.g., develops fever AND respiratory symptoms) she/he should be re-evaluated by a healthcare provider immediately. Infection control precautions should be continued until 10 days after the resolution of fever, provided respiratory symptoms are absent or improving.

- If the illness does not progress to meet the case definition, but the student has a persistent fever or unresolving respiratory symptoms, infection control precautions should be continued for an additional 72 hours, at the end of which time a clinical evaluation should be performed. If the illness progresses to meet the case definition, infection control precautions should be continued as described above. If case definition criteria are not met, infection control precautions can be discontinued after consultation with local public health authorities and the evaluating clinician.

If you have questions about a specific situation, an epidemiologist with the Division of Epidemiology and Immunization, Epidemiology Program is available 24 hours per day, 7 days per week to assist you (617) 983-6800.

You may also use this situation to reinforce basic hygiene and infection control with all students and staff. The most effective means of SARS prevention, and prevention of many other infectious diseases, is good hand hygiene. Frequent handwashing with soap and water or an alcohol-based hand gel or rub is imperative. Also, one should always cover his/her nose and mouth with a tissue when coughing or sneezing. Make sure students and staff have adequate access to handwashing facilities. Remind students not to share food or beverages.

Because SARS is a newly identified syndrome, information is rapidly changing. For the most up-to-date information regarding SARS, including the SARS case definition, high-risk areas for SARS and infection control precautions, see the Centers for Disease Control and Prevention SARS web site: http://www.cdc.gov/ncidod/sars/index.htm.

Refugee and Immigrant Health

Roundtables on Refugee and Asylee Health

During January and February 2003, the Refugee and Immigrant Health Program (RIHP) hosted a series of five roundtable discussions across the state to explore issues related to refugee and asylee health. The roundtables, organized to provide information, feedback and guidance to RIHP, as a forum for discussion among refugees, asylees, and persons from public health, community health, refugee resettlement, mutual assistance associations, and community based organizations. Approximately 110 people actively participated in the roundtables, representing a wide variety of backgrounds and roles.

While much of the discussion focused on refugees and asylees, many of the points made were relevant to newcomers, generally. Among the issues identified were:

♦ Language access for health services continues to be of concern, particularly for newer communities and in settings other than major hospitals.

♦ Gaps between health services providers and newcomer communities exist and result in poor utilization of available health services and low levels of awareness about newcomers among providers.

♦ A broad range of public health services – including communicable disease control, substance abuse services, oral health, school health, domestic violence, health promotion, and HIV prevention, clinical and case management services – are important for newcomers. Cultural and linguistic accessibility is crucial.

♦ Paying for health care is problematic, as refugee/asylee medical benefits are time-limited and many entry level positions do not have health benefits. Providers, as well, cited the complexity of eligibility requirements for public insurance programs and changing benefits.

♦ Addressing mental health needs remains a challenge. Refugees and asylees are at risk for adjustment disorders and anxiety as well as the physical consequences of torture and trauma. There is a need for quality mental health services that are culturally and linguistically accessible.

♦ Asylees are not recognized within communities nor by health care providers for a number of reasons. There is a need for outreach and information related to asylees in order to increase linkage with available services and improve the quality of services.

♦ Refugee children and elders have unique needs that are often unrecognized or unmet. Children may have been witness to violence, had interrupted schooling, and arrive with limited English skills. Elders are often isolated both within their ethnic communities and from the larger community, and face many challenges in accessing services.

Participants discussed strategies to address identified needs. Most focused on increased partnerships, information sharing, bilingual/bicultural outreach, and education and training. The rich discussions that were part of each roundtable were invaluable.

Somali Bantu

During May 2003 the first group of Somali Bantu refugees to be resettled in the U.S. departed from Kenya. In 2000, the U.S. pledged to consider for resettlement 10-12,000 Somali Bantu, most of whom have been in refugee camps for years and cannot return to Somalia. While processing was delayed post-9/11, it now appears that this particular group of at-risk refugees will begin to move to the U.S.

The Somali Bantu were originally brought to Somalia as slaves in the 18-19th centuries from east and southern Africa. Although freed during the colonial period, most Bantu continued to be in low status positions in society. In a society that revered nomadic culture and clan connections, Bantu were settled agricultural workers without the protection of a clan system. During the civil war that followed the overthrow of Siyaad Barre in 1991, Bantu were often the targets of violence and persecution. In 1992, many fled across the border to Kenya, where they remain.

In Massachusetts, Somali Bantu will be resettled with the support of the Greater Springfield Community Partnership for Refugee Resettlement, a collaborative that is led by Jewish Family Service. It is expected that approximately 200 new arrivals will be served by the partnership over a two to three year period. In addition, resettlement agencies in Boston and Worcester have been approved to resettle Somali Bantu, although arrivals in these areas are dependent on processing and movement from Kenya.

Somali Bantu have had little to no experience with Western health care prior to arriving in the U.S. Strategies to address health issues will need to take this into consideration, together with cultural beliefs and practices.

The Center for Applied Linguistics has completed a Somali Bantu Cultural Profile designed to be of use to a broad range of providers. The profile is available on the web at www.culturalorientation.net.

World Refugee Day 2003

June 20th was designated World Refugee Day by the United Nations High Commission for Refugees (UNHCR). This year the focus was on the 8 million refugee youth worldwide. According to UNHCR, refugee youth are routinely subjected to separation, exploitation, abuse, violence and having much greater responsibilities than they may be prepared to take on. They face exposure to HIV/AIDS, risk for military recruitment, and extremely limited access to education.

In the words of Ruud Lubbers, UN High Commissioner for Refugees, "A refugee's life is never an easy one, but it's especially tough on young people who are robbed of what should be the most formative, promising and exciting years of their lives. At a time when they should be full of hope and dreams for the future,

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New Reportable Diseases and Isolation and Quarantine Requirements

Culminating two and a half years of work by the Massachusetts Department of Public Health (MDPH), Bureau of Communicable Disease Control, and its public health partners, the revised 105 CMR 300.000: Reportable Diseases and Isolation and Quarantine Requirements were issued on February 14, 2003. These regulations have been comprehensively updated to incorporate new federal communicable disease surveillance recommendations and the latest recommendations for isolation and quarantine. The last time these regulations were comprehensively amended was in 1992, with a HIV/AIDS surveillance specific modification in 1998.

In preparing the revision of the regulations the Bureau of Communicable Disease Control convened an advisory committee comprised of representatives from local boards of health, other Bureaus of MDPH, professional organizations and other public health professionals and partners. The advisory committee met numerous times over two years and provided initial input and comment.

The revisions include the addition of 17 reportable diseases or conditions. Also clarifications and modifications include: by whom and to where should case reports be sent, what information is required in case reports, definitions of specific terms, issues of confidentiality and access to medical records, temporary reporting requirements on an emergency basis, and laboratory reporting.

The new information, including a summary of the changes, is available on line at www.state.ma.us/dph/cdc/epii/epi.htm#reporting. Also posted are three different lists of the new reportable diseases: Diseases Reportable by Healthcare Providers; Diseases Reportable by Laboratories; and Diseases Reportable by Local Boards of Health.

World Refugee Day

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they are instead faced with the harsh reality of displacement and deprivation."

Staff with the Refugee and Immigrant Health Program acknowledged World Refugee Day reflected on their own experiences and that of their sixteen refugee communities that have resettled in the U.S. over the last 28 years. This diverse staff exemplifies the vibrancy and strength found within refugee communities.

Human Monkeypox Infection Identified for the First Time in the United States

Over 80 cases of suspect human monkeypox infection have been reported in the United States. These cases represent the first evidence of community-acquired monkeypox infection in the U.S. Cases had onset of illness beginning in early May 2003 and all cases had direct or close contact with recently purchased, ill prairie dogs.

Human monkeypox is a rare febrile rash illness caused by an orthopoxvirus and is seen primarily in the rainforest of Central and West Africa. African rodents act as the major reservoir for the virus, sporadically spreading the virus to other rodents, lagomorphs (hares and rabbits), and primates, including humans. Human symptoms begin with fever and muscle aches progressing to include a pustular, smallpox-like rash, and prominent lymphadenopathy. The rash can involve the palms of the hands and the soles of the feet, but fewer lesions appear on the body than with smallpox and patients are much less sick. Unlike smallpox, the lesions can occur in crops and therefore may be at various stages of development. The average incubation period is 12 days (range 7-21 days). Person-to-person transmission is rare but possible. The case fatality rate ranges from 1-10%.

The current outbreak of monkeypox in the U.S. has been linked to close contact with prairie dogs distributed to two pet stores as well as during two pet "swap meets" held in Wisconsin and Illinois. Prior to their sale, the prairie dogs were exposed to several rodent species from Africa, including a sick Gambian giant rat. Animal tracebacks are ongoing. No prairie dogs or African rodents were transferred to Massachusetts from the suspect facilities.

The Massachusetts Department of Public Health recommends that people avoid contact with prairie dogs, Gambian giant rats and other wild or exotic pets that appear ill (e.g., are missing patches of fur, have a visible skin rash, or have eye or nasal discharge). In addition, persons in contact with prairie dogs, Gambian giant rats, or other wild or exotic animals should thoroughly wash their hands with soap and water after touching the animals.

It is illegal to own wild animals in Massachusetts without obtaining a permit from the Division of Fisheries and Wildlife. As of June 11, 2003, the CDC and FDA have prohibited the importation of all rodents from Africa due to the potential that they can spread monkeypox. Also prohibited is the sale, distribution, transport, or release into the environment of prairie dogs, and specific rodents from Africa.

Additional monkeypox information may be accessed on the CDC web site: www.cdc.gov/ncidod/monkeypox/index.htm

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http://www.state.ma.us/dph/cdc/update/comnews.htm

As a web-based publication, we will be able to produce issues more frequently. Please bookmark the web site and check it frequently for news.

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